Discharge Planning Role

Documentation:

Information:

Discharge Planner Orientation Checklist

Discharge Planner Name:_____ Facility:_____
MHC Name:_____ R3 Coordinator Name:_____
Date of Hire: _____

Date Finished	Initials of Staff Involved	DP initals	Task
			Basic Facility Training/Orientation
			Risk Reduction & Reentry Coordinator
			Spend 1 day with a DP from another facility
			COR-Pathways (phone conference if not located at LCF/EDCF)
			Release Planning Coordinator / Release Planner (IPO)
			Classification Administrator
			Unit Team Manager
			Unit Team Counselor
			Statewide Mental Health & Substance Abuse Specialists(phone conference)
			Kansas Parole Board Administrator (phone conference)
			Local Parole Office (day of shadowing w/ Parole Officer)
			Kansas City or Wichita Parole Office (if that isn't the local parole office for day of shadowing w/ specialized Mental Health PO)
			Local Community Mental Health Center (tour)
			Mirror/CRB in Wichita & Topeka (as time/travel permits)

If any of the elements above were not done, please explain: _____
_____
_____

Checklist Completed. DP Sign/Date _____

Within 30 days after completion, please e-mail this form to X or fax to X (please keep a copy in the your file)

FOR INFORMATION ABOUT WHO TO CONTACT AT YOUR FACILITY – CONTACT:

Shannon Tullis-Meyer, Assistant Reentry Director
ShannonT@doc.ks.gov 785-213-9640

DISCHARGE PLANNING TIMELINE

Please Complete for ALL Offenders who qualify for discharge planning

Offender Name:_____ KDOC#:_____

Release Date:_____ Date Offender Referred to DP:_____

Date of First Contact:_____ Parole Violator YES NO

MH Treatment Need (1-7): ___ MH Disorders (1-6): ___ MH Treatment Received (1-7): ____

General Physical (1-5): _____ Medical Classification (M-1 to M-6): _____

italic items should be documented in EMR/TOADS

for each task, write date completed (or N/A if not done) on line _____

12 to 14 months

1. Receive caseload from R3 Coordinator _____
2. List all offenders level 3+ on <u>any MH scale</u> in case-tracking spreadsheet _____
3. Initial interview with offender (use standard interview packet) _____
4. Review Charts, EMR, OMIS/TOADS info on offender _____
5. *Offender __Does __Does Not need discharge planning*
6. *Document in TOADS that offender ___Is ___Is Not on your caseload* _____

If Offender Refuses Services

Offender has refused discharge planning services (after 3 attempts by DP to engage)

Dates of Attempts: 1._____ 2._____ 3._____

Reason for Refusal_____

*Notify Unit Team Counselor of Refusal and Document details in TOADS*_____

6-12 months pre-release

1. *Meet with offender every 2 months (list dates)*_____
   (TOADS/EMR meeting documentation should always include what was discussed)
2. *Refer to needed Risk Reduction & Reentry Services (does he need job/ cog services, employment class, etc.?) Service:* _____ *Date:* _____
3. *Coordinate case with those who need to be involved to plan this release (job/cog, sex offender staff, housing specialists, MHC, etc.)* _____
4. *Call CommunityWorks at 866-429-6757 if offender likely TBI or severe physical disability (LCF and TCF only)* _____
5. Continue to address any barriers and discuss options to help eliminate them

4-6 months pre-release

1. Start gathering information for Social Security and GA apps _____
2. Start to identify necessary community resources (mental health, indigent health clinics, non-profits for help with food/meds/etc.) _____
3. Start work on specialized housing needs (NF, NFMH, hospital, etc.) _____
4. *Start meeting monthly w/ offender 3 months pre-release* _____

3 months/90 days pre-release

1. *Meet monthly with offender (document in EMR/TOADS)* _____
2. *Apply for Social Security (call Social Security for interview appt.)* _____
   (Document Social Security interview/application completion in TOADS)
3. *Contact Vocational Rehab if offender wants job training/help* _____
4. *Work with MHC on State Hospital Commitment if necessary* _____
5. Check TOADS/Release Plan for detainers (still need to complete discharge planning, since many detainers are resolved before release) _____
6. *Schedule screenings for Nursing Facilities or NFMH if needed* _____
7. Prepare GA app packet (inc. medical records) so it's ready to send 30 days pre-release (please attach GA checklist to this form) _____

1 month/30 days pre-release

1. *Send GA app to SRS Regional Contact and e-mail PMDT* _____
2. Prepare CMHC referral form (w/ RDU report, EMR notes, med list…) _____
3. *Offender meeting with psych nurse to learn about their meds* _____
4. *Meet weekly with offender—Dates:* _____
5. Address offender's questions/concerns _____

2 weeks pre-release

1. *Make/verify CMHC appointment-- CMHC Name* _____ *Date*_____
2. *Send referral form to CMHC (inc. EMR notes, RDU report, med list…)* _____
3. Phone family/friends (support system or residence providers) with education (behaviors to watch for, med info, necessary appointments, etc.) _____
   best to speaker phone call with offender in your office (and get release of info)

1 week pre-release

1. *Make one contact with offender—Date:* _____
2. Review KDOC Release Plan for detainers, release info, etc. _____

3. Answer any questions the offender may have and let them know how to contact you if they need help after release (90-day aftercare) _____
4. Complete discharge plan in EMR _____
5. *Clearly note on discharge plan:*
    a. *If you have applied for GA/SSI and any follow-up info:* _____
    b. *What resources you've contacted (and if successful—ex: if you screened for NFMH and were denied or which nursing facilities denied admission or if a CMHC refused to make an appt., etc.)* _____
6. *Check status of GA/SSI applications* _____
7. *Make sure all info about placements applied for, agencies contacted, services recommended in community, etc. are documented in TOADS and EMR* _____

Day of Release (DP initial/sign or N/A on line for each step _____)

1. *Meet offender in A&D*
2. Review release plan/discharge plan with offender (CMHC appt., follow up with benefits contact, community service appointments, etc.) _____
3. Give packet of resource information (important phone numbers, community agency info, discharge plan, etc.)_____
4. *Check that they have 30-day medication supply (or 7 day for some)* _____
5. Provide your (DP) contact info and remind of 90-day aftercare _____
6. Contact SRS Regional Contact to confirm release info _____
7. Give offender letter on how to contact SRS upon release _____
8. *Send letter about contacting SRS to Parole Officer and document need to/how to follow up with SRS benefits in community in TOADS (so PO can know)*_____
9. *Send copy of discharge plan to:*
    a. *CMHC contact (also include KDOC release plan)* _____
    b. *Parole Officer:* _____
    c. *Mirror (if applicable):* _____
    d. *Any agency providing case mgmt. (CommunityWorks, MRDD, etc.)* ____

Aftercare

1. *30 day contact: what/with whom* _____ *date:* _____
2. *60 day contact: what/with whom* _____ *date:* _____
3. *90 day contact: what/with whom* _____ *date:* _____
4. *Complete COR-P/DP Data Tracking Form* _____

Entering Chronos and FPER Codes

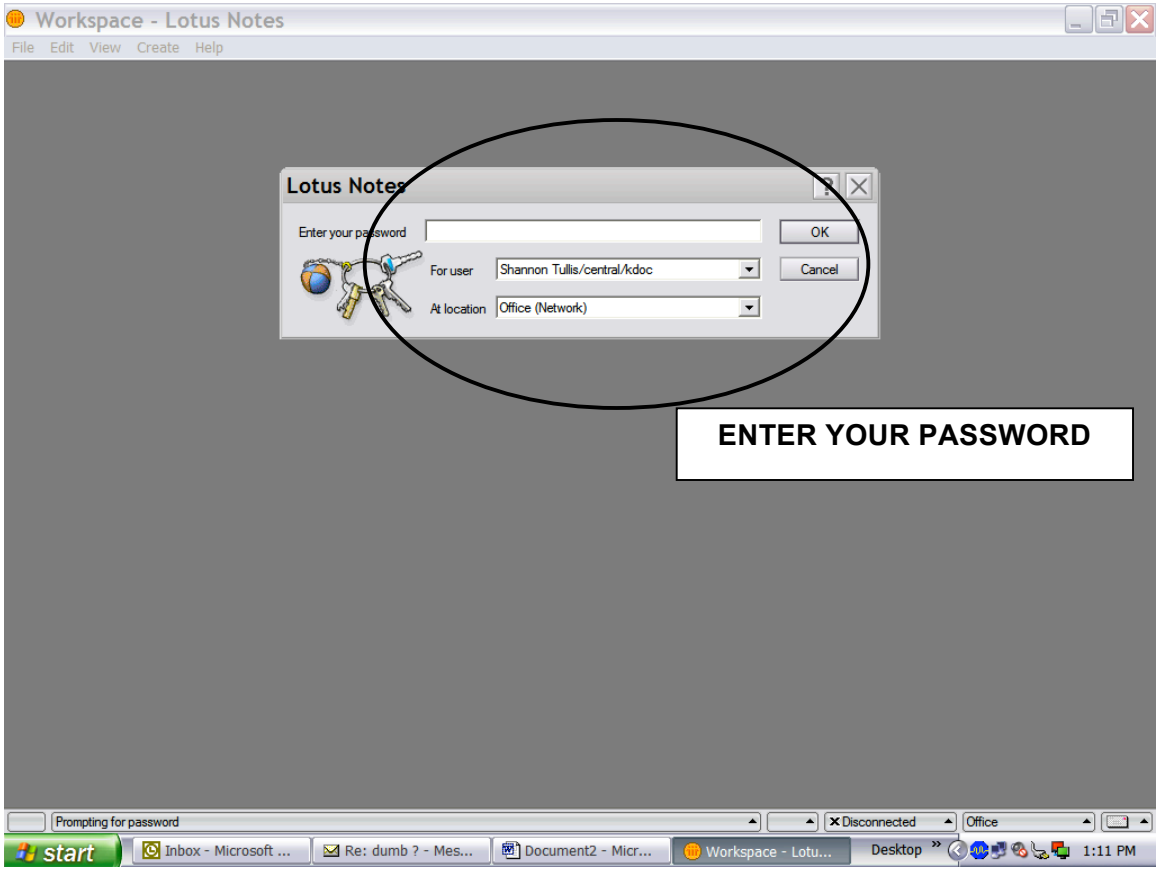
Chronos:
All italicized items in the DP Checklist (completed for each case) should be entered into TOADS chronos. Please see the next 5 pages on how to enter chronos. Here are some examples of entries. All entries need the date and time of contact from the drop-down menus above the contact notes. <u>You cannot put diagnoses or names of medications in chronos!!</u>

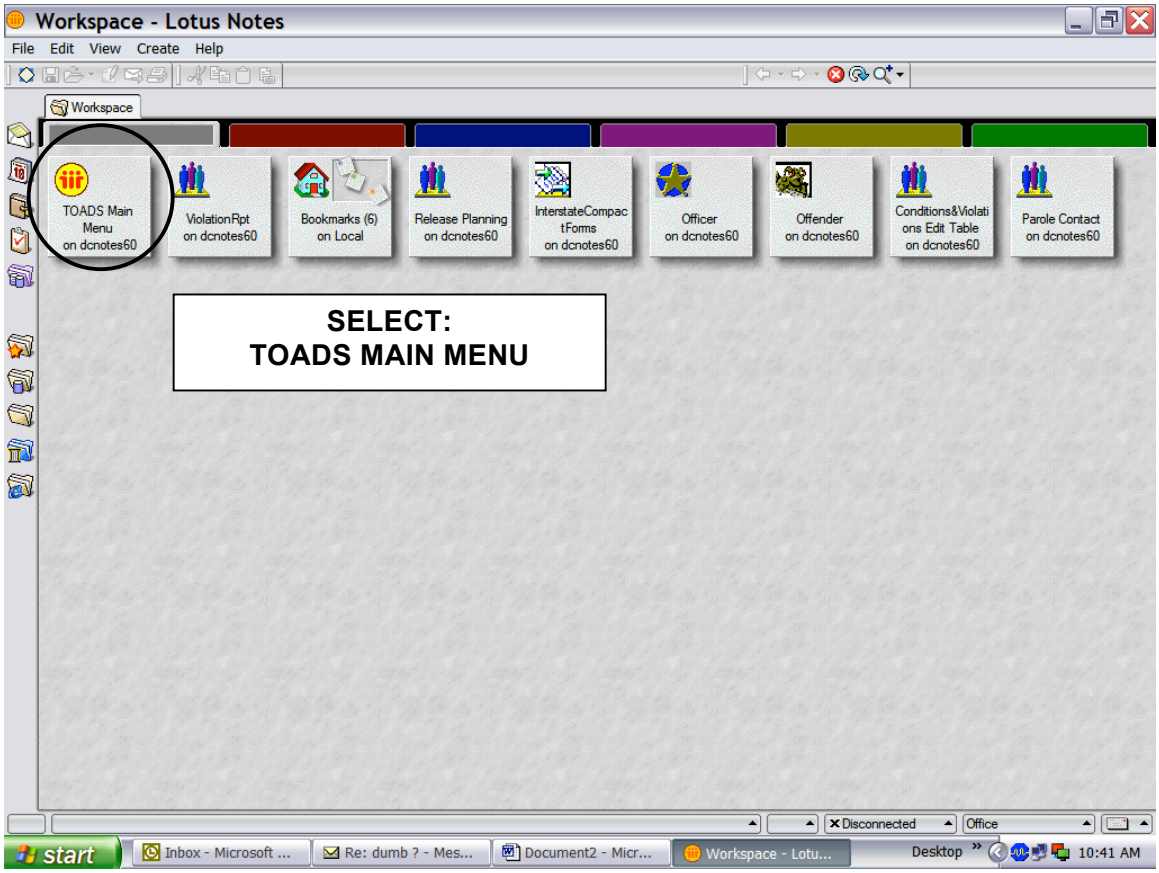
Examples:

1. *Joe has been added to my discharge planning caseload. My first meeting with him will be December 1, 2008.*
2. *I had a meeting with Joe today. He signed all of the forms to complete his GA application. He is going to move back to Topeka where he went to Valeo before. Verified in TOADS that the Reentry Plan (to his brother in Topeka) has been submitted to the Release Planner. He plans to go back to Valeo.*
3. *I delivered Joe's GA application to the Lansing SRS Office on November 19, 2008.*
4. *SRS notified me on December 22, 2008 that Joe's GA application has been denied.*
5. *I scheduled an appointment for Joe at Valeo for Sept 7 at 9am. I spoke with Jane Smith at intake. Her phone number is 555-555-5555.*

FPER codes (Facility Program Experience Record):
FPER codes are entered in OMIS to track what programs an offender has been involved in, whether the programs/services were completed/terminated, etc. Instructions for entering these as well as the codes for termination reasons follow later in this section. You will need to get your specific FPER code from your R3 Coordinator. It is very important that you enter these codes to ensure that discharge planning is counted as a servce that the offender participated in. Please use the termination codes provided and ask your R3 Coordinator any questions about which code to use.

ENTERING CHRONOS IN TOADS

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Bookmarks (6) on Local
Release Planning on dcnotes60
InterstateCompactForms on dcnotes60
Officer on dcnotes60
Offender on dcnotes60
Conditions&Violations Edit Table on dcnotes60
Parole Contact on dcnotes60
SELECT:
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Inbox - Microsoft ...
Re: dumb ? - Mes...
Document2 - Micr...
Workspace - Lotu...
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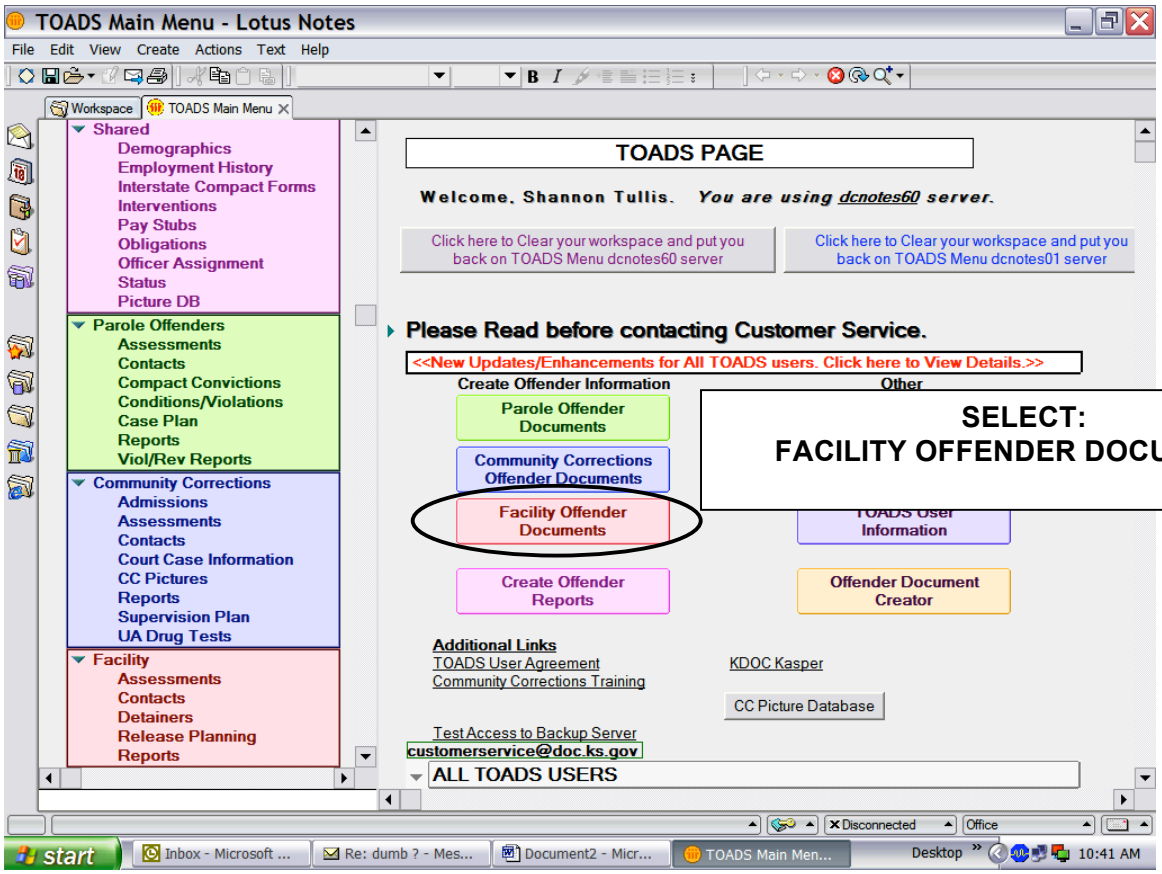
10:41 AM


TOADS Main Menu - Lotus Notes
File Edit View Create Actions Text Help
Workspace
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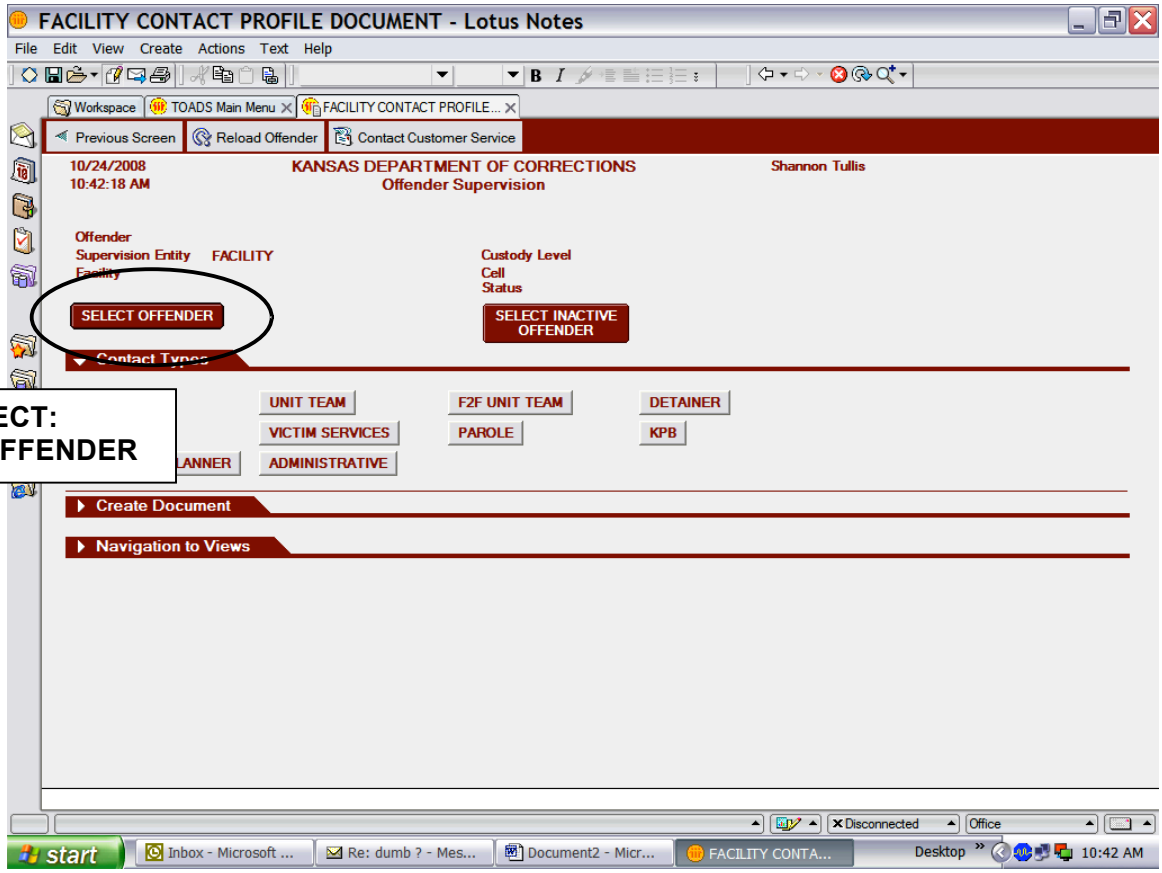
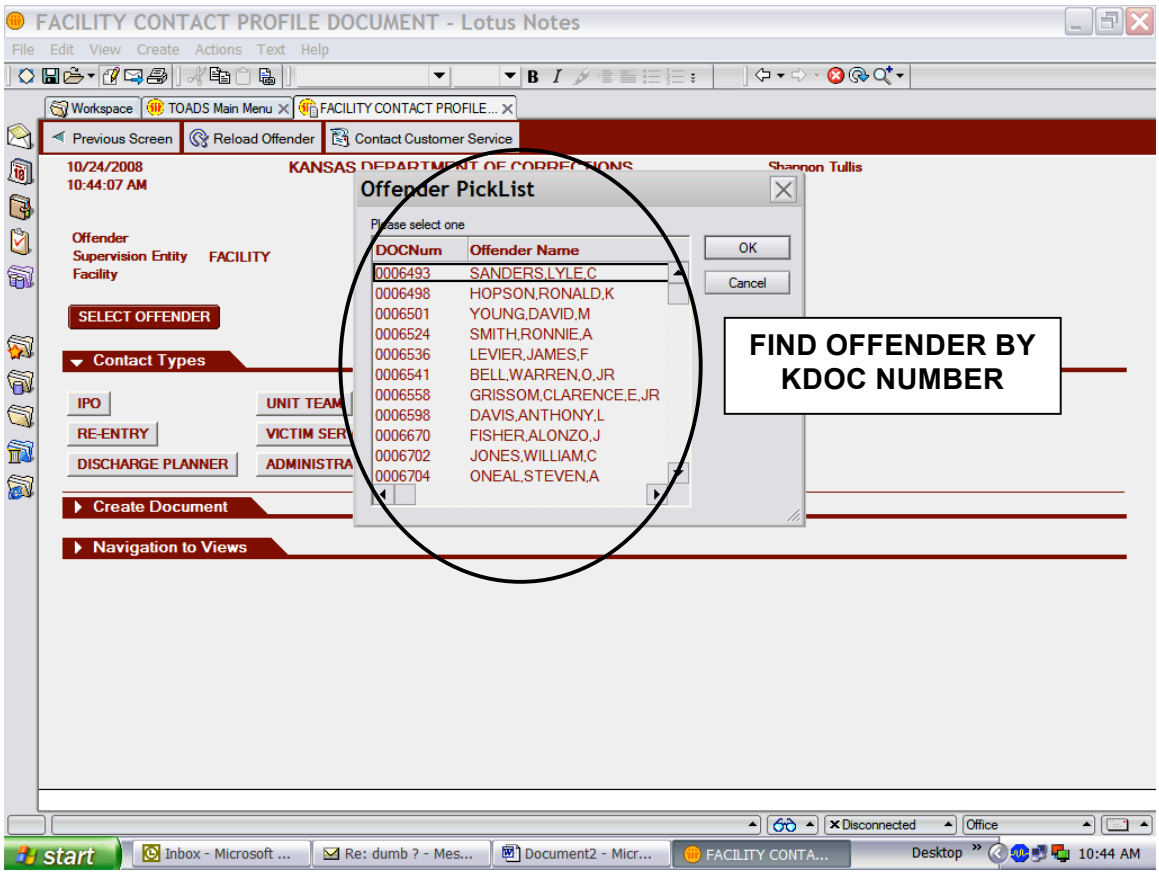
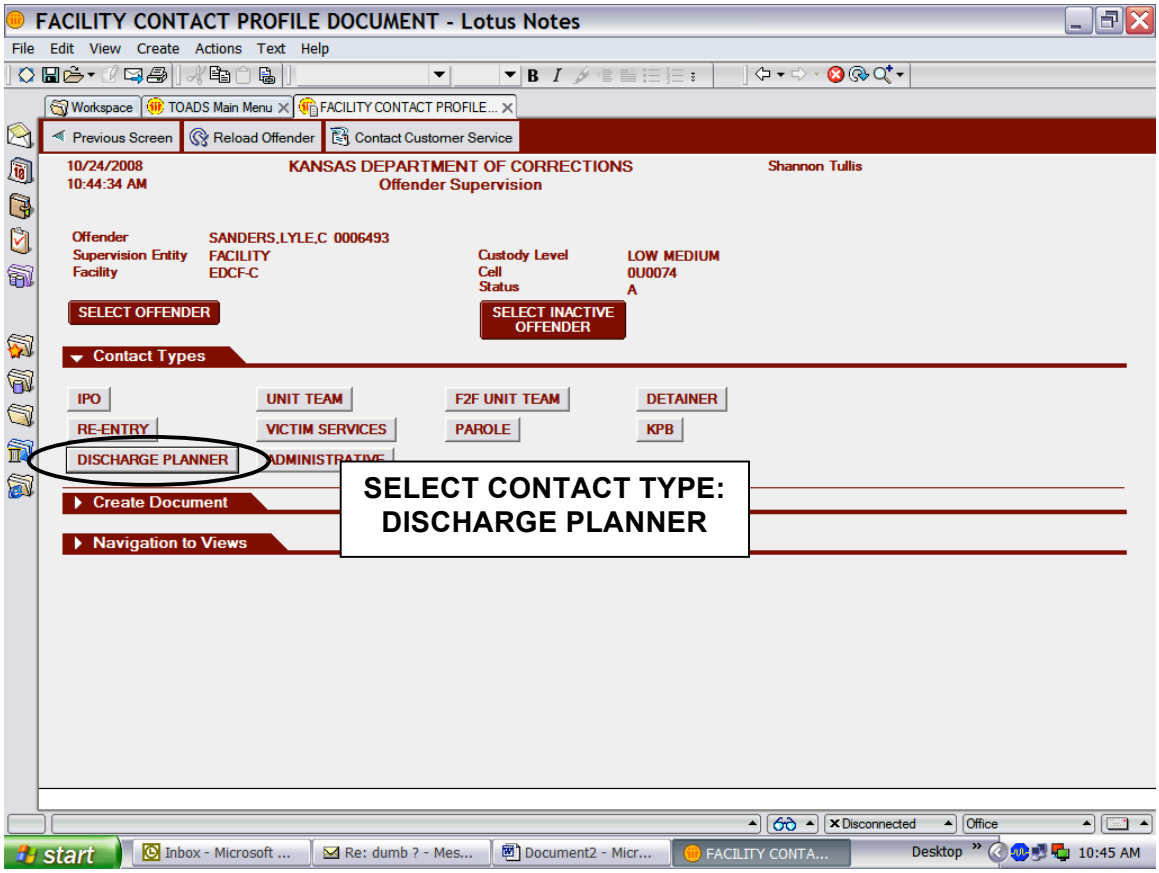
Shared
Demographics
Employment History
Interstate Compact Forms
Interventions
Pay Stubs
Obligations
Officer Assignment
Status
Picture DB
Parole Offenders
Assessments
Contacts
Compact Convictions
Conditions/Violations
Case Plan
Reports
Viol/Rev Reports
Community Corrections
Admissions
Assessments
Contacts
Court Case Information
CC Pictures
Reports
Supervision Plan
UA Drug Tests
Facility
Assessments
Contacts
Detainers
Release Planning
Reports
TOADS PAGE
Welcome, Shannon Tullis. You are using dcnotes60 server.
Click here to Clear your workspace and put you back on TOADS Menu dcnotes60 server
Click here to Clear your workspace and put you back on TOADS Menu dcnotes01 server
Please Read before contacting Customer Service.
<<New Updates/Enhancements for All TOADS users. Click here to View Details.>>
Create Offender Information
Other
Parole Offender Documents
Community Corrections Offender Documents
Facility Offender Documents
Create Offender Reports
Offender Document Creator
Additional Links
TOADS User Agreement
Community Corrections Training
KDOC Kasper
CC Picture Database
Test Access to Backup Server
customerservice@doc.ks.gov
ALL TOADS USERS
SELECT:
FACILITY OFFENDER DOCUMENTS
Disconnected
Office
start
Inbox - Microsoft ...
Re: dumb ? - Mes...
Document2 - Micr...
TOADS Main Men...
Desktop
10:41 AM

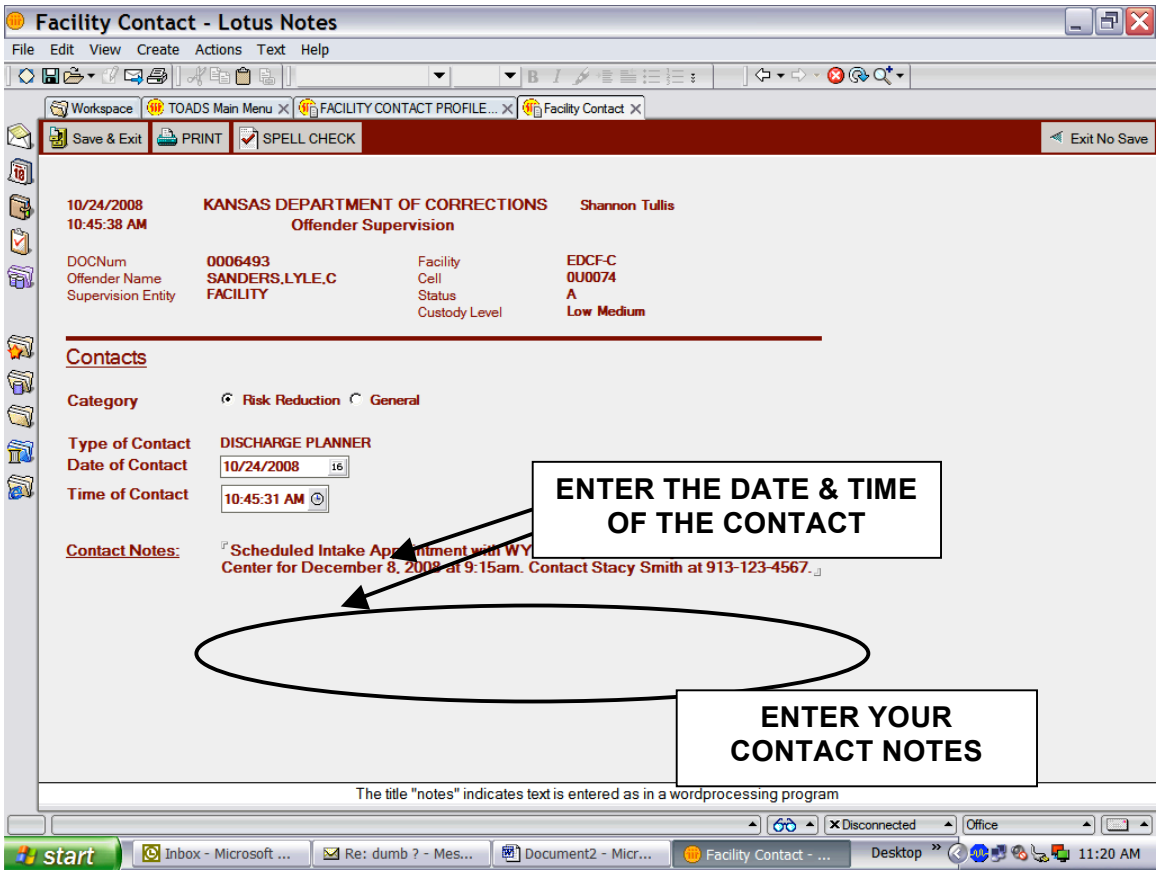


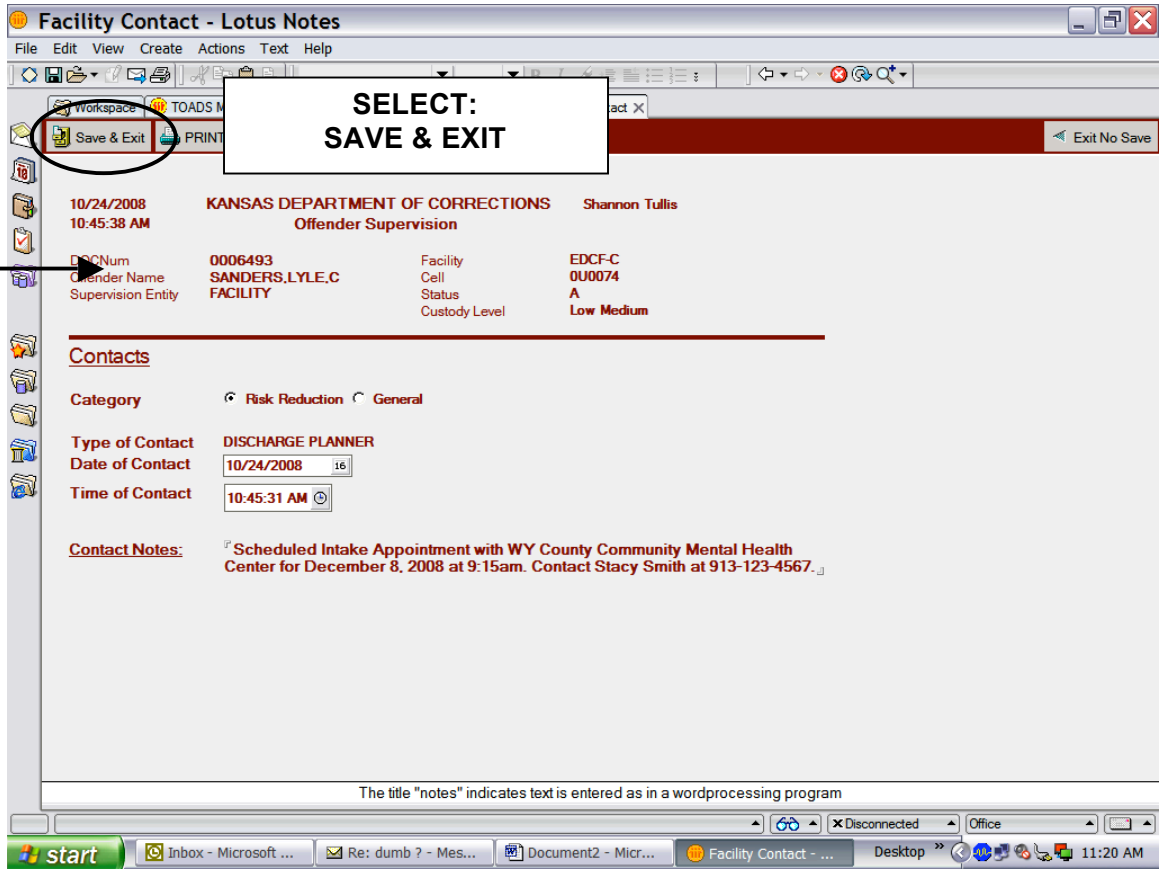
SELECT:
SELECT OFFENDER



FIND OFFENDER BY KDOC NUMBER


FACILITY CONTACT PROFILE DOCUMENT - Lotus Notes
File Edit View Create Actions Text Help
Workspace
TOADS Main Menu
FACILITY CONTACT PROFILE...
Previous Screen
Reload Offender
Contact Customer Service
10/24/2008
10:44:34 AM
KANSAS DEPARTMENT OF CORRECTIONS
Offender Supervision
Shannon Tullis
Offender
SANDERS,LYLE,C 0006493
Supervision Entity
FACILITY
Facility
EDCF-C
Custody Level
LOW MEDIUM
Cell
0U0074
Status
A
SELECT OFFENDER
SELECT INACTIVE OFFENDER
Contact Types
IPO
UNIT TEAM
F2F UNIT TEAM
DETAINER
RE-ENTRY
VICTIM SERVICES
PAROLE
KPB
DISCHARGE PLANNER
Create Document
Navigation to Views
SELECT CONTACT TYPE:
DISCHARGE PLANNER
Disconnected
Office
start
Inbox - Microsoft ...
Re: dumb ? - Mes...
Document2 - Micr...
FACILITY CONTA...
Desktop
10:45 AM


Facility Contact - Lotus Notes
File Edit View Create Actions Text Help
Workspace
TOADS Main Menu
FACILITY CONTACT PROFILE...
Facility Contact
Save & Exit
PRINT
SPELL CHECK
Exit No Save
10/24/2008
10:45:38 AM
KANSAS DEPARTMENT OF CORRECTIONS
Offender Supervision
Shannon Tullis
DOCNum
0006493
Offender Name
SANDERS,LYLE,C
Supervision Entity
FACILITY
Facility
EDCF-C
Cell
0U0074
Status
A
Custody Level
Low Medium
Contacts
Category
Risk Reduction
General
Type of Contact
DISCHARGE PLANNER
Date of Contact
10/24/2008
Time of Contact
10:45:31 AM
Contact Notes:
Scheduled Intake Appointment with WY
Center for December 8, 2008 at 9:15am. Contact Stacy Smith at 913-123-4567.
ENTER THE DATE & TIME OF THE CONTACT
ENTER YOUR CONTACT NOTES
The title "notes" indicates text is entered as in a wordprocessing program
Disconnected
Office
start
Inbox - Microsoft ...
Re: dumb ? - Mes...
Document2 - Micr...
Facility Contact - ...
Desktop
11:20 AM



MAKE SURE YOU HAVE THE CORRECT OFFENDER BEFORE SAVING

FPER (Facility Program Experience Record) Quick Reference

TO ENTER A FPER RECORD:

1. From the OMIS Main Menu, type Option #1 (MAINTENANCE MENU) and press enter

2. Once the Maintenance Menu has opened type press the "Page Down" button on your keyboard approximately 4 times (when you see the Programs heading stop). Type an 'X' on the blank line next to the "Add/Update Program Experience Records" option and press enter.

3. This screen prompts the user for very specific information:

KDOC#:	
Facility:	
Unit Designation:	(Facility A A, LCFC - only)
Program:	
Schedule:	
Title Code:	
Date Entered Program:	

4. Please refer to the attached spreadsheet for the FPER code(s) that correspond to your respective service. ***NOTE: Please remember:***
   a. "Program" for Reentry Programs will always be 'RR'
   b. "Schedule" is always 'P' for Part-time
   c. "Date Entered Program" cannot be before 7/1/2007

TO TERMINATE A FPER RECORD:

1. From the OMIS Main Menu, type Option #1 (MAINTENANCE MENU) and press enter

2. Once the Maintenance Menu has opened type press the "Page Down" button on your keyboard approximately 4 times (when you see the Programs heading stop). Type an 'X' on the blank line next to the "Add/Update Program Experience Records" option and press enter.

3. This screen prompts the user for very specific information:

KDOC#:	
Facility:	
Unit Designation:	(Facility A A, LCFC - only)
Program:	
Schedule:	
Title Code:	
Date Entered Program:	

NOTE: *The information here will need to* ***match the information put for the offender when the FPER was entered****.*

It may be helpful to print a roster (Reports Menu), Report #147. This report will give you a list of offenders currently in the programs (according to Program Experience Records), by program code.

Once the information has been entered, press enter.

4. The next screen will provide you with a display of the Program Experience Record's information to date. This will most likely be information regarding the entry dates.

   NOTE: Please verify all information on the screen is correct, i.e., make sure this is the record for which you want to enter a termination date/reason.

   a. On the "Date Terminated Program" enter the date which the inmate terminated the program;
   b. Press 'F7' to select Termination Reasons.

      Note: For Termination Reasons, 04 Prog, work, custody transfer, 05 Medical/Mental Health-Temp, 10 Reached Maximum Benefits, the user must enter comments, i.e., provide a brief description/explanation.

   c. Press enter.

Termination Reasons

1) PROGRAM COMPLETED: Use when the individual has completed the program or service. In geographic-based reentry programs, use this code when the individual has completed the inside/facility portion of the program.

2) PROGRAM PROMOTION: Out of use.

3) FACILITY TRANSFER (non-volitional): Use to designate program terminations resulting from a transfer to another KDOC facility, for any reason.

4) TRANSFER TO DIFFERENT CUSTODY UNIT OR SEGREGATION (non-volitional): Use to designate program terminations resulting from a) transfer to a different custody unit in the same facility, b) placement in segregation. Put a or b in comment section.

5) TEMPORARY MEDICAL/MENTAL HEALTH ISSUE(s) (non-volitional): ***Not used for R3 programs and services.***

6) REFUSED TO PARTICIPATE (volitional): ***Not used for R3 programs and services.***

7) RELEASED OR DISCHARGED FROM FACILITY (non-volitional): ***Not used by R3 programs and services.***

8) DISCIPLINARY/POOR PERFORMANCE (volitional): ***Not used for R3 programs and services.***

9) REFUSED TO ENTER (volitional): ***Not used by R3 programs and services.***

10) ATTAINED MAXIMUM PROGRAM BENEFIT (non-volitional): a) Use when the individual is unable to benefit from further participation in the program; or b) when the individual chooses not to complete the program or service. Put a or b in comment section.

11) PERMANENT MEDICAL/MENTAL HEALTH CONDITION (non-volitional): ***Not used by R3 programs and services.***

12) GED PENDING: ***Not used by R3 programs and services.***

13) DETERMINED EDUCATION NOT NEEDED: ***Not used by R3 programs and services.***

14) DETERMINED TRADITIONAL PROGRAM NOT NEEDED: ***Not used by R3 programs and services.***

15) CHOSE NOT TO COMPLETE. Use when individual chose to discontinue program or services. (This will replace 10.b when it is coded/programmed.)

16) PLACED IN SEGREGATION. Use when individual is placed in segregation so program or service could not be delivered/completed. (This will replace 4.b when it is coded/programmed.)

COR-PATHWAYS/DISCHARGE PLANNING SERVICES RECORD AND DATA COLLECTION SHEET

Offender Name & KDOC #: _____ Date Started: _____

COR-P Assigned: _____ DP Assigned: _____ UT Counselor: _____

Age: _____ Race: W B H A O Managed as SO: Y N

Most Recent Most Serious Offense Category: SO Person Drug Property Other

Latest Admission Date: _____ Release Date: _____

Latest Admission Type: NCC PVNNS PVNS PbVNNS PbVNS

MH Level: 6 5 4 3 2 1 Unknown

Medical Level: 5 4 3 2 1 Unknown

Did offender sign releases for you to give/get information about his/her care Y N
If N, reason: _____

Primary Reason Services Provided:
_____ Major mental illness diagnosis (schizophrenia, major depression, bi-polar and/or psychotic disorder)
_____ Medical need (frail elderly, major illness, chronic disease)
_____ Other: _____

How did you get this case?
_____ Offender requested services
_____ CCS referred case
_____ Unit team counselor referred case
_____ Case assigned by _____
_____ Other

On this case did you,
Complete a disability application Y N
If Y, status at time of release: _____
Complete a general assistance application Y N
If Y, status at time of release: _____
Complete an application for other benefits Y N
If Y, what benefit(s): _____
If Y, status at time of release: _____

On this case did you make a referral to:

CMHC Y N
If Y, which one: _____
If Y, status at time of release: _____
If Y, was an appointment made for offender upon release Y N
If Y, how many days after release: _____
If N, why not: _____
Nursing home Y N
If Y, which one: _____
Status at time of release: _____
To a state hospital Y N
If Y, status at time of release: _____

On this case did you

Address housing in any other way Y N
If Y, status at time of release: _____
Have contact with the offender's family Y N
If Y, reason: _____
Provide other case management services Y N
If Y, briefly state what services not already listed:

_____
_____

Did the parole officer have contact with this offender before his/her release? Y N
If Y, which parole officer, and how many times: _____

Date services ended: _____

How did the services with this offender end:

_____ Released from prison ____ to supervision ____ discharge w/o supervision
_____ Offender chose to stop participating
_____ I terminated him from the services/program because of his/her behavior or lack of cooperation/participation
_____ Offender was moved to another facility
_____ Other: _____

Offender released with medication Y N
If Y, quantity: _____ How confirmed: _____
If Y, and less than 30 days, reason: _____
If N, reason: _____

Offender released to,

[here use same list we're using in release plan for type of release]

FOLLOW UP FOR OFFENDERS WHO COMPLETED PROGRAM/SERVICES:

_____ Checked with CMHC re first appt within 7 days Y N Couldn't find out
Results: _____

_____ 30-day check with parole officer Y N
Results: _____

_____ 30-day check with CMHC Y N
Results: _____

_____ 60-day check with parole officer Y N
Results: _____

_____ 60-day check with CMHC Y N
Results: _____

_____ 90-day check with parole officer Y N
Results: _____

_____ 90-day check with CMHC Y N
Results: _____

Reported parole violations and results:

Reported revocation and reason:

Reported new conviction; if so date and type (sex, person, drug, property, other) and results:

Caseload Decision Process

Every facility has been using different criteria to determine who will receive discharge planning services. This practice will now be standardized across the facilities using the following steps:

1. The R3 coordinator will give the discharge planner a list of those they will serve
2. The discharge planner will note in TOADS that they received the offender's name and what services they provided for the offender
3. Every offender served will have a completed discharge planning checklist as well as a COR-P/DP data sheet completed and kept in a file

Case Responsibility Flow Chart

<u>Risk Reduction & Reentry (R3) Coordinator</u>
receives Reentry Planning Release Report

↓

R3 Coordinator assigns caseloads to CORP and/or CCS Discharge Planner
* if no COR-P at facility, all MH and/or Medical cases go to CCS Discharge Planner *

Mental Health only	Medical only	Mental Health & Medical	None
↓	↓	↓	↓
SPMI (level 6*) – COR-P MR (level 5*) – COR-P MI (level 3-4*) – CCS	divide evenly between COR-P & CCS	COR-P	other R3 staff or UT counselor

*These levels are based on the MH Disorders scale (see MH scales on pg. 22—MH Disorders is the 2nd Scale)

EMR (Electronic Medical Records)
Mandatory Documentation

1) All inmate contact, phone contact regarding inmate's case, information related to Release of Information and other agency contacts will be documented in EMR. If contact information is related to parole, information could also be documented in TOADS.
2) Locate inmate by utilizing the patient search engine. This can be accomplished by using the KDOC inmate number or the inmate's first and last name.
3) Select the inmate chart.
4) Open a new Mental Health encounter. Enter the facility location, the task—Discharge Planning and the employee title. Scroll down and click on Progress Note. This will produce a list of options. Choose Administrative Note.
5) In the Administrative Note, there will be another list of options. Choose Discharge Planning as the purpose of the note. In the text area, begin the note. When there are no more spaces available, scroll down and enter a date for any follow up contact that has been scheduled. Click on Document.
6) EMR will generate a document of all information that has been entered. If the note was incomplete, the writer can continue the note, in the document format. There is unlimited text.
7) The note should indicate what the contact involved and if the inmate was present during the action. The reader should have a clear understanding of what occurred during the contact and what is the next needed step.

Supervisory Roles—KDOC vs. CCS

Administrative Supervisor—

The CCS discharge planner will have one administrative supervisor who is:

- Employed by CCS
- Generally the Mental Health Coordinator (MHC) for that facility
- Administrative Supervisor provides:
    - Clinical direction
    - Administrative oversight for issues related to paid leave
    - Evaluation processes
    - Disciplinary interventions (if needed)
    - All staff evaluations for CCS Discharge Planner (with input from Reentry Coordinator)

Day-to-Day Supervision—

The CCS discharge planner will also work under the Reentry Coordinator who:

- Provides the day-to-day oversight/supervision
- Assigns tasks related to caseload
- Clarifies assignments
- Coordinates with the CCS discharge planner and the other reentry staff
- Does not have the authority to impart discipline—directs those concerns to MHC

Mental Health and Related Codes

Mental Health Treatment Need

1) Not currently requiring mental health services
2) May require time-limited mental health services
3) Requires on-going mental health services that may include medication management
4) Requires special needs treatment monitoring
5) Requires mental health structured reintegration program at LCF-TRU
6) Requires intensive mental health placement at LCMHF or TCF-MHU
7) Requires hospitalization at LSH

Mental Disorders

1) None, exclusive of a primary substance abuse/dependence diagnosis
2) Primary diagnosis of a paraphilia or a Personality Disorder which is not the focus of treatment
3) Diagnosed with a transient mental disorder that is the primary treatment focus and less than six months in duration
4) Serious mental health disorder on AXIS I/II
5) Primary diagnosis of mental retardation
6) Severe and persistent mental illness

Mental Health Treatment

1) Not currently requiring mental health
2) Receives time-limited mental health services
3) Receives on-going mental health services that may include medication management
4) Receives special needs treatment monitoring
5) Placed in mental health structured reintegration program at LCF-TRU
6) Placed in intensive mental health placement at LCMHF or TCF-MHU
7) Hospitalization at LSSH

Housing Considerations

2) Placement at a facility with on-site mental health services, including psychiatric services
3) Appropriate for multi-man housing in facilities with comprehensive mental health services
4) Requires single cell due to a mental disorder
5) Requires structured housing in a mental health unit

Employability

1) No limitations on employment
2) Requires limited supervision
3) Can work under moderately structured, supervised conditions
4) Can work in a high structure/low demand setting
5) Disabled due to a mental disorder

Medical Classification Codes

P	U	L	H	E		X
General Physical	Upper Extremity	Lower Extremity	Hearing	Eyes		Medical Classification
1 Good to excellent medical condition.	1 No impairment	1. No impairment	1 No impairment	1 No impairment		M-1 Able to handle any work assignment or, despite mild medical problems able to work and handle any work assignment.
2 Average to good medical condition	2 Slight impairment does no limited working with hands	2 Slight impairment; does not limit walking, standing, climbing.	2 Slight impairment; no hearing aid needed.	2 Vision correctable to 20/20. No worse than 20/100.		M-2 Mild medical problems; may handle most work assignments
3 Fair to Average medical condition	3 Moderate impairment does limit working with hands, arms, shoulders	3 Moderate impairment does limit walking, standing, climbing.	3 Hearing aid indicated	3 Limited vision; use of glasses necessary.		M-3 Unfit for any work assignments but capable of light housekeeping in own living area.
4 Fair to poor medical condition	4 – Severe impairment may limit working with hands, arms, shoulders	4 Severe impairment does limit walking, standing or climbing	4 Sever impairment – does need hearing aid	4 Limited vision – depth perception due to loss of one eye.		M-4 Due to medical condition, totally dependent for personal needs.
5 Poor medical condition needing close medical support or special consideration.	5 Loss/paralysis of limb, decreased upper body strength, range of motion.	5 Loss/paralysis of limb; decreased lower body strength, range of motion.	5 Deaf in one or both ears to the extent that special consideration is needed.	5 Loss of vision in one or both eyes to the extent special consideration is needed.		M-5 Severely limited physically or inmate not to transfer until clearance given by medical department.
KEY: P U H L E X P: Physical capability, stamina > 1 – strongest; 2 – slight limitation; 3- weak or very limited; 4 – bedridden 5 - terminal or medical work-up in progressp; 6-pregnant U: Upper extremities > 1 – strongest; 2 – some limitation; 3-significant limitation; 4-missing arm 5 - no arms L: Lower extremities > 1-strongest; 2 – some limitation; 3 – significant limitation; 4- missing leg; 5- no legs H: Hearing > 1- normal; 2 – some impairment; 3 – significant impairment; 4- deaf in one ear; 5 - deaf E: Eyes/Vision) > 1-20/20 both eyes; 2 – some impairment; 3 – significant impairment; 4-blind in one eye; 5-total bilateral blindness X: Medical Factors > classification status on a scale of 1 to 6 (see chart)						M-6 Inmate not to transfer until clearance given by mental health.

Disorder	How to Recognize	How to Respond
Mental Retardation/ Developmental Disability (MR/DD)	*IQ less than 70 (or severe adaptive skill deficits) *described as "slow", "low functioning" *mental skills very low for their age *search files/RDU report for any reference to a "Community Developmental Disorder Organization" *Axis II Diagnosis of "Mental Retardation"	*These offenders will need extra help with discharge planning-- they may be unable to complete applications/tasks on their own *May seem higher-functioning than they actually are (may have learned how to mask their disorder) *Call your nearest Community Developmental Disability Organization to plan referrals, service options, apply for SRS waiver, etc. *Find documentation in med records, RDU report, etc. to support need for MR/DD services *make sure to give information about possible MR/DD issues to any referrals you make (CMHCs, RADAC, etc.) *You MUST complete a GA pre-release application at least 30 days pre-release-- almost all services for MR/DD require Medicaid
Traumatic Brain Injury (TBI)	*MOST IMPORTANT QUESTION: Did you ever have a blow to the head (ex: vehicle accident, sports injury, blastwave from explosion- for vets) that caused you to lose consciousness, go to ER, stay in hospital, etc. *search files and RDU report for evidence of head injury (car accident, head blow during fights, domestic violence, sports injury, war injury-- explosion nearby, etc.) *symptoms may include-- --impulsive, aggressive behavior --failure to understand cause and effect (can't link their actions and the consequences) --substance abuse and mental health disorders commonly co-occur (*often mistaken for ADHD) *often viewed as defiant or "liars" b/c they *just don't get it* *May have IQ in normal range	*These offenders will need extra help with discharge planning-- they may be unable to complete applications/tasks on their own *May seem higher-functioning than they actually are (may have learned how to mask their disorder) *may seem uncooperative "pain to work with" *Call your nearest Center for Independent Living to plan referrals, service options, apply for SRS waiver, etc. *Find documentation (RDU reports, med records, etc.) to support need for TBI services *make sure to give information about possible TBI issues to any referrals you make (CMHCs, RADAC, etc.), since it will impact their treatment plan *You MUST complete a GA pre-release application at least 30 days pre-release-- almost all services for TBI require Medicaid
Fetal Alcohol Spectrum Disorders (FASD)	*MOST IMPORTANT: Did their mother drink during pregnancy (offenders often do not know this answer or won't say) *distinctive facial features (less common in adults) *similar behaviors/interventions as TBI (above)	*These offenders will need extra help with discharge planning-- they may be unable to complete applications/tasks on their own *May seem higher-functioning than they actually are (may have learned how to mask their disorder) *may seem uncooperative "pain to work with" *no specific FASD services through SRS-- look for community orgs in area *make sure to give information about possible FASD issues to any referrals you make (CMHCs, RADAC, etc.), since it will impact their treatment plan *FASD does not qualify as a TBI-- they may qualify for physical disability services if their condition is severe enough to interfere with their activities of daily living *You MUST complete a GA pre-release application at least 30 days pre-release

Example Reception and Diagnostic Unit Report

(RDU Report for fictional inmate)

PSYCHOLOGICAL TESTING: Mr. Doe was administered the MCMI-III and the General Ability Measure for Adults (GAMA).

The MCMI-III is a self-report, clinically-based inventory of psychological functioning. The Corrections Report was utilized; results were valid and interpretable. Overall, the MCMI-III indicated that Mr. Doe intended to represent himself in a more favorable manner than is accurate. However, his TABE reading level of 5.2 renders the results of the MCMI-III invalid.

The GAMA uses non-verbal, geometric patterns to estimate current mental ability, and derives an "IQ equivalent" score. His score of 91 indicates overall functioning between the low average and average range.

The SRA-99 is an actuarial assessment tool used to establish the possible sexual and violent recidivism potential of those convicted of sexually motivated offenses. Mr. Doe's score of 5 identified him as a medium-high risk to sexually re-offend at this time. The score also indicated a 40% chance of sexually re-offending and a 52% chance of violently recidivating within 15 years. His score was influenced by his unrelated, male, stranger victim, his prior sentencing dates, and the non-contact nature of his sex offense.

MENTAL STATUS EXAMINATION: This 54 year old black male, appearing his stated age, presented to the interview appropriately dressed and with good hygiene. He was given the standard waiver of confidentiality, and he stated that he understood and accepted as such. Mr. Doe related in a friendly manner, though he frequently expressed his resentment and lack of trust for the system as he feels he was purposefully mistreated by being kept in RDU for 7 weeks prior to his assessment; this MHP attempted to help him understand that such was an accident that happened because someone classified him as a condition violator, but he was unwilling to consider such as possible. He was alert and oriented to person, place, time, and situation throughout the interview. He maintained good eye contact throughout the interview and was most cooperative and easily engaged, however his extreme level of paranoia precluded him from sharing much information about his social history. Affect was abnormally variable, ranging from euthymia to irritability; mood congruent. There was no significant anxiety noted. Speech is coherent, but very pressured as he had a lot of frustration to vent regarding the legal system; he was not easily redirected and perseverated on how he has been mistreated recently and throughout life. Though content is frequently delusional and often tangential; however, he is able to articulate himself very well and communicate coherently. He denies a variable mood, and endorses few of the neurovegetative signs of an affective disorder, and none were observed. Hallucinations and illusions were not evident, but delusions of persecution are suspected. Brief intellectual assessment suggests performance in the average range, with other neurocognition

(concentration, acquisition of information, recall to delay, problem solving, and executive functioning) consistent with this level of functioning. There was no indication of suicidal or homicidal ideation, and such were denied. Insight is poor; judgment is poor.

CURRENT SYMPTOMS: Mr. Doe denies any current symptoms of a mood, thought, or anxiety disorder. This MHP considered delusional disorder and paranoid personality disorder and it appears that he meets the diagnostic criteria for delusional disorder. The following symptoms are apparent; paranoid belief that most people are "out to get him", claiming that his substance abuse counselor was tampering with his UA's as he vehemently denies using drugs besides alcohol, feeling that he is a victim of racism multiple times per day when white people smile at him, believing he is "a superior mental being" and providing this MHP an example by correctly guessing her astrological sign, believing that God specifically answers his prayers when he prays, frequently ranting about spirituality, and feeling that many women are in love with him (his PO's notes in TOADS suggest he felt she was courting him when completing a routine assessment and asking about his marital status).

It appears these delusional beliefs have caused Mr. Doe to experience occupational and social dysfunction for many years. Records indicate he admits to being on SSI for a mental health disorder and that he has received such benefits for many years; he was unwilling to speak about these benefits because he "can't trust the system." It is possible his apparent substance abuse problem may have exacerbated these symptoms, but he denies ever using drugs; it is difficult to associate such with his disorder. Due to Mr. Doe's paranoia and unwillingness to discuss his past, it is unknown why he receives SSI and for how long he has experienced his symptoms as he denies ever having received mental health services or medication for a mental health reason. Delusional disorder, mixed type, will be diagnosed. Mr. Doe refuses mental health services at this time and was informed of how to access such in case he changes his mind. He states that he feels adjusted to the prison setting

CURRENT OFFENSE: Mr. Doe is currently incarcerated for a fourth time DUI. He received a KDOC number while serving his time in county jail in March of 2006 and was placed on parole when released from jail 3/24/2006. He was revoked from parole for having several dirty UA's and failing to complete his substance abuse treatment. He admits to his offense, but minimizes such and expresses great resentment for how the legal system has cheated and mistreated him since 1984.

CRIMINAL HISTORY: Mr. Doe has a history of convictions for vagrancy, indecent exposure, and aggravated battery- intentional bodily harm starting at age 21. There is no record of juvenile convictions, and Mr. Doe denies such. This is his first term in the KDOC, although he received a KDOC number previously without physically entering the KDOC.

SOCIAL HISTORY: Mr. Doe was reluctant to report much regarding his social history. Most of what is reported in this section has been compiled from reviewing his file. Mr. Doe apparently

graduated from high school in 1965, attaining a diploma. He served in the Navy for 1.5 years in the late 1960's and was dishonorably discharged for refusing to go to Vietnam. He was employed in a fiberglass workshop for 2.5 years in the 1960's and this appears to be his longest term of employment. He has primarily been supported by SSI benefits and says he earns $939 per month and that such is enough live on, but that he supplements his income by recycling. He spends most of his time collecting cans and other recyclable materials. He has been residing in the same residence the past 4 years and reports that he likes this residence but may have to move because "too many people are curious about [his] life."

Mr. Doe reports he was married about 7 years in the past, with the divorce occurring about 25 years ago. He was unwilling to say whether he has any children. He stated that he loves many women and that many women love him, but he did say he has one special woman that he likes more than the others. His PO noted that he admitted to using drugs once when he had a lady friend over. He presented himself as a man with a very active sex life.

Mr. Doe says he is the middle child of 5 children born to his parent's marriage. He cites being raised in a supportive environment by his parents and says he and his family members were always close when he was growing up. He reports his father was a school teacher and his mother a missionary and therefore had a strong religious emphasis in his home environment. Mr. Doe reports both his parents died within a year of each other in 2002 and 2003. He was more evasive when asked about his current relationships with his siblings and other family members and would only say "we have family communication."

SUBSTANCE ABUSE HISTORY: Mr. Doe was evasive and irritable when discussing his substance abuse history. He reports that he is "a recovering alcoholic" and refuses to admit to any further use of drugs. While he was on supervision, he had the following positive UA's, morphine (5/2006), cocaine (5/2006, 8/2006, and 9/2006) and marijuana (8/2006).

SEX OFFENDER EVALUATION: Records indicate that Mr. Doe is convicted of the following: indecent exposure, Sedgwick County, 7/5/1975. There was no official information available at the time of this report. Mr. Doe says he and a few of his friends were admiring a car when they were approached by police and accused of planning a burglary. He says he created a distraction for his friends to get away by pulling down his pants and urinating in front of the officers. He reports being arrested at that time and was convicted of the offense, but not required to complete a sex offender treatment program or register as a sex offender. There have been no subsequent sexually-related offenses. There is no indication for a sex offender treatment program.

Mr. Doe was unwilling to discuss his personal sexual history due to the nature of his sex offense and the lack of being designated as a sex offender in the past. This MHP found such as acceptable and did not pressure him through a sexual history due to his mental health disorder complicating his ability for such.

PSYCHIATRIC HISTORY: Mr. Doe denies any previous mental health treatment. He reports no history of symptoms of a major mental illness, but Delusional Disorder is apparent in the assessment today and such is also supported in his file. He denies any past or present suicidal or homicidal ideation. He denies any history of abuse or head injury. Though he denies such, this MHP assumes he must have received some type of mental health services in the past as he has told other staff that he receives SSI for a mental disorder.

FAMILY HISTORY: Mr. Doe reports no family history of mood, thought, or anxiety disorder.

REVIEW OF SYSTEMS/PAST MEDICAL HISTORY: Denied as noncontributory. See also current medical evaluation in his records.

CURRENT MEDICATIONS: Mr. Doe does not take any medication for mental health purposes. He currently declines mental health services, but agrees to access such if he feels such is needed to function at his normal level.

EVALUATION: Mr. Doe's presentation, history, and testing indicate an individual with Delusional Disorder, mixed type. There is no indication of a maladaptive personality structure. There is a current pattern of polysubstance dependence (alcohol, cocaine, morphine, and cannabis).

RECOMMENDATIONS: 1. Mr. Doe is to receive mental health services as needed and appropriate.